UNITED NATIONS
*Office on Drugs and Crime*

Regional Office for
South Asia

# PREVENTION OF TRANSMISSION OF HIV AMONG DRUG USERS IN SAARC COUNTRIES

TD/RAS/03/H13

3

## SAFER PRACTICES

**INTERVENTION TOOL-KIT**
UNDER TESTING

**Intervention Tool-kit**
(A set of six modules)

**An UNODC-ROSA undertaking**
For the AusAID supported project 'Prevention of transmission of HIV among Drug Users in SAARC Countries' (Project code- TD/RAS/03/H13)

**Module 3**
Safer Practices

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# Intervention Tool-kit

## Module-3

Safer Practices

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AusAID

## EXTRACT FROM THE OPENING STATEMENT OF ANTONIO MARIA COSTA, UNODC EXECUTIVE DIRECTOR, AT THE 48th SESSION OF THE COMMISSION ON NARCOTIC DRUGS, VIENNA, MARCH 7–14, 2005

In many countries, the current dramatic spread of blood-borne infections, from HIV/AIDS to Hepatitis C, is aggravating the suffering that comes from the chronic abuse of drugs. As a result, people at risk of HIV, or already infected by AIDS need tangible, targeted, and immediate help before this pandemic evolves into the biggest killer in history.... My office is mandated, via the UN Drugs Conventions, not just to reduce the prevalence of drug abuse, but also **to reduce the harm caused by drugs**.

The best form of dealing with the problem is, of course, abstinence and at UNODC, we've invested substantial resources in prevention and treatment. We are increasing the assistance to populations at high HIV/AIDS risk, and we work with governments so that they can reach people before they join the ranks of the HIV-positive. This is where we can make a significant difference. This is where resources are well spent, as it is always easier to attack a problem before it materialises, or spins out of control.

My office believes that greater attention and more resources should be invested in drug control programmes aimed at checking the spread of blood-borne diseases. These initiatives must not stand alone, but be part of **comprehensive efforts** aimed at reducing drug use. We unequivocally reject any initiative, well-intended as it may be, that could lead to a perpetuation of drug abuse... Governments can, and must **ensure both drug control and HIV prevention**.

As stated by the INCB in its 2003 report: *"... governments need to adopt measures to reduce the demand for illicit drugs taking into account... the drug-related spread of HIV infection. At the same time,... prophylactic measures should not promote and/or facilitate drug abuse."*

## UNODC'S COMPREHENSIVE PACKAGE APPROACH

HIV/AIDS prevention and care programmes for injecting drug users typically include a wide variety of measures (the 'package' approach), ranging from drug dependence treatment, including drug substitution treatment, outreach providing injecting drug users with information on risk reduction and referral to services, clean needles and syringes, and condoms, voluntary counselling and testing, treatment of sexually transmitted infections, antiretroviral therapy, and interventions for especially at-risk populations such as prisoners and sex workers who inject drugs. Such a comprehensive package of measures also usually includes treatment instead of punishment for persons convicted of minor offences, since drug treatment not only constitutes a humane, cost effective alternative, but also incarceration usually increases the risk of HIV transmission.

# CONTENTS

# 1. AIMS

The current module on 'Safer Practices' is the third in the series of the six modules of the intervention tool-kit developed under the UNODC-ROSA project entitled 'Prevention of transmission of HIV among Drug Users in SAARC[1] Countries' (Project code- TD/RAS/03/H13). The aims of the current module are:

- To provide an overview of the benefits of safer practices against a backdrop of injecting drug use in different parts of the world with examples from South Asia.
- To describe the guidelines for implementing services for safer practices.

[1] SAARC is the South Asian Association for Regional Co-operation.

# 2. INTRODUCTION

At present, there are more than 13 million injecting drug users (IDUs) worldwide, and in some regions more than 50 per cent of them are infected with HIV (UNAIDS, 2004). The shift from traditional psychotropic substance use of opium and cannabis to non-traditional use in Asian countries has been characterised over the last three decades by the introduction of injecting use of heroin and/or synthetic pharmaceuticals such as buprenorphine or dextropropoxyphene. Sometimes, a mixture of drugs such as buprenorphine, antihistaminic preparations and sedatives is also injected.

Drug injecting with contaminated equipment and injection paraphernalia has now become the major HIV transmission mode in many parts of the world. Among the seven member-countries of SAARC[2], the four which have recorded injecting drug use to a considerable degree are Pakistan, India, Nepal and Bangladesh. The remaining three (Sri Lanka, Bhutan and Maldives) have documented just a few cases. Injecting drug use in these countries is characterised by heterogeneity – both in the course taken by the HIV epidemic among IDUs and the types of drugs used. Despite this heterogeneity, what is nonetheless common among IDUs here is the self-reported high rates of injecting equipment sharing, which have given rise to alarmingly high Hepatitis C prevalence in these countries and high HIV prevalence in some places. The cost of syringes in the region is significantly higher in real terms than in several high income countries. This negatively impacts on the ability of IDUs to acquire needles and syringes as many of them come from poor economic backgrounds and leads to greater sharing of injecting equipment by IDUs in South Asia (Pandas and Sharma, 2005). Moreover, the fear of being punished if apprehended by the police (who can use possession of syringe and needles on person as an indirect evidence of drug use) has also forced many drug users in South Asia to share injecting equipment.

While it is logical and easy to appreciate, against this backdrop, that making sterile syringe and needles available to IDUs-as part of a package of comprehensive services–will go a long way in preventing several health and social consequences in relation to injecting drug use, the appropriateness of such an approach has been questioned. Some of the arguments put forward against the provision of sterile syringes and needles to IDUs in exchange for old and used ones are:

- Programmes promoting Safer Practices will encourage non-injecting drug users to start using drugs by injecting and will also increase drug use in general in a community.

[2] SAARC member-countries are Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka.

- A Safer Practices programme will send a wrong message that the government's commitment to 'fight drugs' has softened and attention is being diverted away from abstinence-oriented programmes.
- The HIV epidemic related to injecting -drug -use is an independent and isolated epidemic. It is, therefore, not going to impact in any significant way on the heterosexually-driven epidemic, which is the major epidemic of concern. Thus, no special programme such as Safer Practices for IDUs is necessary.
- Why spend money on Safer Practices for IDUs when there are more important health issues such as inadequate supply of sterile syringes and needles for expanded programme of immunisation?

None of the above-mentioned concerns is, however, well founded. Increased access to sterile syringes and needles has been shown to effectively curb the spread of HIV infection among IDUs (Hurley *et al*, 1997; Hartgers *et al*, 1989) around the world and have served as referral sources for health related issues (Dolan *et al*, 1993). Programmes promoting 'Safer Practices' have also been found not to lead to an increase in drug use or an increase in HIV risk behaviours. It is also true that an HIV epidemic in IDUs has the potential to fuel a heterosexually-driven HIV epidemic as witnessed in South Asia (Panda, 2003) and averting HIV infections among IDUs would help the health system of a country from being overwhelmed by waves of HIV disease-related morbidity and mortality that would appear 5 to 10 years later. Finally, a government can still go strong on drug demand and supply reduction as well as abstinence-oriented programmes while endorsing Safer Practices, as these approaches are complementary rather than conflicting public health approaches. While one (drug supply and demand reduction) deals with primary prevention of drug use, the other deals with consequences of drug use and attempts to reduce resulting harms (areas under secondary and tertiary prevention).

In the South Asian context, Nepal provides an interesting case study in this regard. The sudden increase in HIV prevalence in 1997 from zero to 50 per cent among IDUs led conservative elements within the country to question supply of sterile syringe and needles and its effectiveness in preventing HIV epidemics. Even more worryingly, some individuals suggested that it was the existence of such projects that had led to the explosive HIV epidemic among IDUs. However, a retrospective study conducted among 200 IDUs in 1998-1999 suggested otherwise. Those IDUs who had at any stage been clients of the Safer Practices programme operated by a local NGO (Life Giving And Life Saving Society), which also supplied sterile syringes and needles, were 40 per cent less likely to contract HIV than those who were not. While the findings of this study are by no means conclusive, they are consistent with findings elsewhere in the world about the health benefits and protection offered against blood-borne viruses by programmes that ensure supply of sterile syringes and needles to IDUs (Reynolds, 2000).

Bangladesh, through a National Assessment of Situation and Responses to Opioid/Opiate use in the country (NASROB), provides additional compelling evidence on the benefits of Safer Practices (Panda *et al*, 2002). Direct and indirect sharing of injecting equipment reported by IDUs in this assessment was found to be significantly higher in sites and districts that did not have any outreach intervention (67 per cent and 62 per cent, respectively) when compared with sites having outreach-based programmes promoting Safer Practices (19 per cent and 23 per cent, respectively).

# 3. WHAT NEEDS TO BE IN PLACE BEFORE INITIATING SAFER PRACTICES

The most important step before initiating Safer Practices in a locality is fostering community support, including support from law enforcement officials. For a detailed discussion on this topic, see subsection 4 of the present module. Two other activities that need to be conducted before initiating such a programme are:

a) Situation and response assessment and
b) Capacity assessment of the agency intending to launch Safer Practices

'Situation and response assessment' helps in placing the programme plan in the right perspective and also in explaining to the community at large and police officials in particular why a 'Safer Practices project' appears necessary for a drug using community. Results of any situation and response assessment analysed in relation to the three levels of determinants described in Box 1 succeed in presenting the case better for any particular intervention (in this case, Safer Practices). Against this, capacity assessment of the agency intending to conduct Safer Practices helps in identifying the areas where it might require inputs and drafting of a detailed action plan.

**Box 1: Levels of analysing a situation and presenting a case for the development of a particular intervention (e.g., Safer Practices) or a combination of interventions**

**LEVEL 1: Drug using community**

a. networks of IDUs: sizes of the networks, the extent of bridges between different networks; the members in a network (fixed or changing), drug use norms and practices among network members, with a focus on peer leader influence if any, etc.
b. perception and practices of individual IDUs and their regular sex partners in relation to general health seeking behaviour with a focus on sexual health.

**LEVEL 2: Immediate surroundings of the drug using community**

a. attitudes of the local community at large towards IDUs.
b. addiction treatment and drug use related services existing in the community and the environment there.
c. interface of drug users and injecting drug users in particular with local law enforcement officials.

**LEVEL 3: Policy environment and interpretation**

a. policy environment and existing government schemes for drug users.
b. status of collaboration between the ministry that deals with drug use related issues and the ministry of health and family welfare.

Readers of this module are advised to go through Module 1 of this series for a detailed discussion on how to conduct a 'situation and response assessment' and why it should be followed up quickly with an intervention.

# 4. IMPLEMENTATION OF SAFER PRACTICES

The implementation of Safer Practices will be discussed in the following five subsections. The first subsection on 'information and training on Safer Practices' emphasises why training is necessary and what topics can be covered. The second subsection on 'community sensitisation' highlights the importance of creating an enabling environment for the successful launch and managing of Safer Practices. While subsections 3 and 4, respectively, describe 'materials provided through Safer Practices', and 'modes of delivery', the fifth and final subsection focuses on 'other service provisions and access to functioning and affordable health services'.

I. Information and training on safer practices
II. Community sensitisation
III. Materials provided through safer practices
IV. Modes of delivery
V. Other services provisions and access to functioning and affordable health services

## *I) Information and training on safer practices*

Adequate information and training on Safer Practices should be provided to the staff to ensure quality delivery of services. Discussions during orientation and training sessions should revolve around a wide range of intervention approaches and not just Safer Practices, which would thus help one to appreciate what a comprehensive intervention programme requires for successful implementation, what such a programme can achieve and what it cannot. Examples of a few such interventions that should feature in the discussions are:

**Outreach intervention:** Outreach recognises that drug users are marginalised by society and this in turn negatively affects their access to different health care interventions and services. It, therefore, reaches out to drug users with different intervention messages and materials in the communities where they use drugs or gather. Outreach interventions that have employed ex and/or current drug users as Peer Outreach Workers have been able to reach out to those drug users who have never been in any treatment programme and reduce HIV risk behaviour in them. In fact, many of the intervention approaches mentioned here can be carried out meaningfully only when a regular peer outreach is established as a mainstay. Many outreach programmes have provided HIV/AIDS information-education materials, established links with other health care services, including addiction treatment and substitution, and HIV voluntary confidential testing and counselling services (HIV-VCTC). They have been the means for introducing injecting-related risk reduction steps such as sterile needles and

syringes, and condoms for safer sexual practices. For a detailed discussion on Peer-led Community Outreach, read Module 2 in this series.

**Network intervention:** This intends to work on group norms of drug users by exposing all the members of a network, who were brought in by one of them to a series of group sessions. It is expected that the bond that exists between the members of a group will help them in reinforce each other in observing safer drug-taking practices and because such intervention is targeted towards a group, it will have a better impact in terms of risk reduction than interventions directed towards individuals.

**Education of IDUs:** This is based on the assumption and some study findings that IDUs who are more aware about the risk of HIV through injecting are better able to protect their own health.

**Increasing availability of clean injecting equipment:** The basic tenet of this approach is grounded on abundant evidence that not only is awareness required but making other means of behaviour change available (such as sterile syringes and needles) as part of a comprehensive intervention package is crucial to limiting the further spread of HIV among IDUs.

**Pharmacological intervention:** Two major approaches of pharmacological intervention are: (a) detoxification that aims at treating the physical and psychological discomfort (known as withdrawal) faced by a substance user at the time of stopping drug use through medicines with an ultimate goal of achieving abstinence and (b) substitution treatment where the drug that a user takes is substituted with a similar or identical substance under medical supervision. Substitution may also mean using the same drug but administering it in a different way, for example, sublingual buprenorphine tablets to replace injecting of buprenorphine. Many drug users, through detoxification, can and do achieve abstinence through multiple relapses, as drug use is a chronic relapsing disorder. In the long run, however, it is often difficult to maintain abstinence and many fail. Thus, the second approach – substitution – takes into account the fact that many drug users, consider long-term abstinence a difficult goal to achieve, but still want to protect their health from the risks that might result from continuing drug use and unsafe practices (for a detailed discussion on how to implement substitution treatments, read Modules 4 and 5 in this series).

It is important to appreciate that an injecting drug user who avails of services for Safer Practices may opt at any point of time to switch to other intervention services such as detoxification treatment and his/her choice should always be respected and addressed accordingly. Enrolment of an IDU for Safer Practices should also have similar considerations.

The training workshops dealing with the above-mentioned issues should adopt a participatory training methodology and should be conducted by experienced

trainers. The sessions should address practical issues and enhance the knowledge as well as skills of the participants on the above-mentioned intervention approaches and other related areas. Getting ex-drug users and police officials as resource persons to conduct some of the training sessions often proves beneficial.

Suggested topics for a three-day training workshop are given in (Table 1):

**Table 1: Training staff for Safer Practices programme based on Rapid Situation and Response Assessment findings**

| Day 1 | Day 2 | Day 3 |
|---|---|---|
| Introduction to the workshop<br>Self-introduction by the participants | Recap of the first day<br>Basic communication skills- talking with the community members and assessing their attitudes towards drug users | Recap of the second day<br>Enhancing 'quality' of services- liaison services and linkages with special focus on the regular sex partners of IDUs |
| Ice-breaking exercise so that participants get familiar with each other | How to hold community sensitisation meetings | Materials to be delivered and modes of delivery in a safer practices programme |
| Global overview of drug use and injecting drug use followed by drug use scenario in the country | Advocacy with police | Accidental needle stick injury, safe handling of old and used needles and decontamination of the used needles |
| Sharing of the 'situation and response assessment' findings | How to build trust and rapport with the drug users/ IDUs | Monitoring and quality control (documentation and record-keeping) |
| Different HIV intervention approaches for injecting drug users and what could be appropriate in the light of the situation and response assessment findings | Dos and don'ts in the field | Planning for site visits where safer practices is operating and support for travel |
| Basics on HIV prevention and care | Confidentiality, ethical practices and respecting clients' choices | Feed-back of the participants for the 3rd day of training |
| Feed-back of the participants for the 1st day of training | Feed-back of the participants for the 2nd day of training | |

### *II) Community sensitisation*

Community sensitisation remains pivotal to the success of any Safer Practices programme . The three major purposes that it serves are:

a) Dispelling any misperception that the community at large might have about Safer Practices.

b) Getting diverse community members on board, including police officials.

c) Obtaining community support and participation for ancillary services that some of the clients of Safer Practices or the drug-using community in general might require – e.g., community-based detoxification camps (for a detailed discussion read Module 6 in this series).

In fact, all these considerations hold true for any risk reduction activity that aims at reducing the vulnerability of IDUs to contracting HIV[3] through a comprehensive intervention approach; otherwise, the community might misperceive elements of intervention such as 'Safer Practices' or 'Substitution Treatment' as efforts towards promoting drug use.

Different members of a community exert different influences on drug trade, individual drug users and their networks. They also play important roles in building community attitudes towards different intervention approaches. The power structure in an area, and the influences that each member in this structure holds, will differ from place to place and that is why there is no 'one size fit all' model for conducting community advocacy. However, the following could serve as a useful checklist on the stakeholders who may need to be approached and sensitised in an area while planning services for Safer Practices and other risk reduction activities:

- Law enforcement officials / police (border security force, if appropriate in an area)
- Government officials in the department that deals with the subject of drug use
- Political leaders
- Church leaders
- Youth club officials
- Community elites

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3 The barriers encountered in implementing peer-based outreach to IDUs and how these barriers can be minimised was demonstrated through the Indian Council of Medical Research-World Health Organization (ICMR-WHO) collaborative project during 1994–1996. Launching outreach to the larger community before reaching out to IDUs was found necessary through this work that avoided misperception of the community about outreach-based harm reduction interventions (Hangzo et al, 1997). It was also convincingly shown through this study, (which was carried out in Churachandpur, the southern hilly district of Manipur, a north-eastern state of India having a common international border with Myanmar), that IDUs talked to other IDUs about HIV/AIDS, were capable of initiating HIV/AIDS risk reduction and adopted different modes of cleaning injection equipment such as bleach in order to protect their own health.

- Local NGOs who have been working with HIV and/or drugs since before
- Drug dealers (if possible)
- Local private physicians and hospital doctors
- Local underground pressure groups[4]
- Different donor agencies in the field of drug use and HIV (important for having adequate scaling up at the national level and in turn, impact upon local activities)

The use of either an informal network of friends from the locality (existing from before or developed during assessment of situation and responses) or formal approaches such as extending an invitation to opinion leaders from the community for intervention activities (e.g., official meetings, presentation of situation and response assessment findings, inauguration day of the safer practices project, etc.) helps foster support from different stakeholders and goes a long way in achieving community sensitisation.

### *III) Materials Encouraging Safer Practices*

Services for Safer Practices should not be narrowly focused only on sterile syringes and needles. Instead, they should include behaviour change messages and materials for IDUs for safer sexual practices as well. Moreover, the intervention should be comprehensive in nature and should also reach out to the sex partners of IDUs. However, this does not mean building many vertical systems of care. Ideally, the establishment of referral networks is the key. The range of materials that can be delivered through services facilitating Safer Practices, which will contribute to limiting the spread of HIV, within and from drug injectors, and at the same time reduce other morbidities, such as abscesses due to injecting, are:

- Needles and syringes (which size, what type and how many are to be given on a single visit should be based on situation and response assessment findings)[5]

[4] The north-eastern region of India bordering Myanmar is prone to very high levels of political unrest. The immediate manifestation of this is the presence of various militant organisations claiming to represent ethnic and cultural aspirations. The fiercest of these conflicts exists between the Kukis and the Naga groups. These militant groups seek not just economic control of resources, but also social control of those they claim to represent. They have been known to pass extra-judicial sentences (often manifested in fatal shootings or shooting in the legs as warning) on individuals whose behaviour or stance they deem unacceptable. Hence violence is aimed not only at government structures and members of other tribes and organisations, but also against drug users and peddlers and in some cases those who have been diagnosed as HIV positive (Sharma et al, 2003). Local agencies involved in HIV intervention among IDUs, for example in the state of Manipur, therefore, recognise the local underground pressure groups as one of the key players who need to be brought under the folds of advocacy.

[5] 'One for one' exchange in street outreach has been insisted upon in most of the settings in South Asia as facilities for safe disposal of used syringes and needles are inadequate. Safer Practices should take care of the disposal of the used and returned syringes and needles either through the existing clinical waste disposal scheme of the municipal corporations or incinerators operating in local hospitals. The outreach worker may sometimes (but not as a norm) need to give sterile syringes and needles without getting back the used ones from the IDUs (as lack of sterile equipment may cause unsafe injecting) and one should always insist on 'return' as a means of ensuring adherence to Safer Practices.

- Alcohol/ iodine wipes in small zip bags
- Condoms
- General health information brochures
- Risk reduction educational brochures covering unsafe sex and unsafe drug use for example safer injection practices, vein care, how to put on a condom properly, overdose-related issues, etc. Use of vocabularies in vogue among IDUs and socio-culturally appropriate and attractive design help in better acceptance of these brochures.

Safe disposal of the used and returned syringes and needles should form an integral part of the responsibility of the services for safer practices as indicated in Box 2 describing 'operation G-21' in Imphal, the capital of Manipur.

**Box 2: Safe disposal of the used and returned syringes and needles in Manipur, India (Operation G 21)**

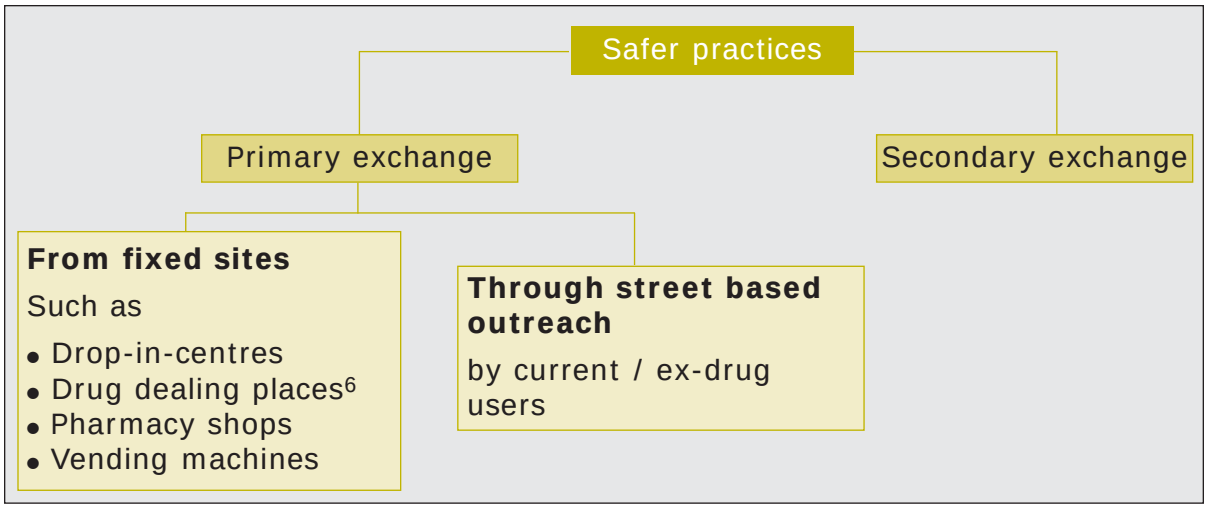
A clean-up drive of used needles and syringes discarded along riverbanks in Imphal (the capital of Manipur), India, took place in September 2001 through Operation G21 (G for Gun - the local slang for syringe; 2=2ml syringes; 1=1ml syringes). Spearheaded by SASO (a local NGO), its objective was to get rid of contaminated injecting equipment dumped along the three marshy riverbank areas in Imphal-North AOC, KR Lane (New Checkon) and Mahabali. Four NGOs are currently working on needle and syringe exchange programmes in these areas.

Operation G21 was needed because of the growing negative sentiment of the community towards needle and syringe exchange programmes as reported by service providers and drug users. The general public felt that the place had become a dumping ground for contaminated 'sharps' disbursed by agencies and pharmacies located nearby. "If you are giving out needles/syringes which are irresponsibly disposed around me after being used by drug users, I don't like your work out here," voiced an alarmed resident. Field visits confirmed the report.

**(Source: AHRN 2002)**

## *IV) Modes of Delivery*

Different modes of carrying out Safer Practices can be diagrammatically represented as follows:




Secondary exchange is defined as making sterile needles and syringes available to the IDUs, irrespective of their contacts with a regular 'fixed site' or 'peer outreach based' Safer Practices programme (primary exchange). The IDUs who are the receivers of sterile needles and syringes from a regular exchange programme serve as secondary exchangers for IDUs who are not in touch with regular exchange programmes. Attempts are also made to identify 'designated exchangers' (mostly current IDUs) in places where Safer Practices are not legal or there is community opposition to visible exchange sites that it feels will promote drug use[7].

### *V) Other service provisions and access to functioning and affordable health services*

After trust and credibility builds between the safer practices service staff and the IDU community, linkages with other services that appear necessary could be developed. Some linkages that appear imminent soon after initiating the programme are:

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6 In Rajshahi, the northwestern district of Bangladesh bordering India, outreach workers by ensuring supply of sterile syringes and needles and return of the used ones practically turned the drug dealers' thatched huts into safe injecting rooms. Previously, the dealers used to inject different clients who bought injection ampoules of buprenorphine from them with the same syringe and needle until the needles turned blunt.

7 The Centre for Social Research and Development (CSRD), an NGO in Calicut in the south Indian state of Kerala, faced community opposition in some areas against opening fixed safer practice sites and also against initiating street-based outreach. The major concern of the community at large was that 'safer practice' would condone drug use. However, the field organisers of CSRD in those areas could identify current users who appreciated the risk of unsafe injecting in spreading HIV and other blood-borne viruses and also saw an increase in injecting drug use in the recent past in their own localities. These current IDUs expressed their willingness to the project field organisers to keep a stock of sterile syringes and needles with themselves that they could deliver to the local IDUs in need of new syringes and needles. "These secondary exchangers expected no monetary remuneration and a secondary safer practice thus got initiated in the northern part of Kerala– a low HIV epidemic state in India. This is an example of how community opposition to safer practice forced a local NGO to find innovative ways to reach out to IDUs with sterile syringes and needles..." [an excerpt from the assessment report prepared for State Management Agency, Kerala and Kerala State AIDS Control Society (KSACS)].

i) Abscess management and treatment for common illnesses,
ii) Referral for drug treatment (detoxification followed by abstinence),
iii) Treatment for tuberculosis,
iv) Investigation and treatment for sexually transmitted diseases,
v) HIV counselling and testing,
vi) Mental and physical health care services,
vii) Legal help, and
viii) Social services such as vocational rehabilitation of IDUs or schooling for children of IDUs.

While abscess management, and syndromic treatment for STDs can be offered at the drop-in-centres (DICs), it is important to establish referral networks for the other services mentioned above. However, the stigma attached to injecting drug users demands that 'accompanied referral' is conducted during the initial years of referring IDUs to other service outlets rather than using just a referral slip. A social worker should accompany an IDU who is in need of these services. DICs can also take part in HIV pre-test and post-test counselling whereas the already existing laboratories in government hospitals could be used for HIV testing.

The idea is to use as many existing services as possible through referral linkages rather than establishing parallel vertical systems of service delivery so that a bridge is finally built between the 'marginalised hard-to-reach population of IDUs' and the 'mainstream service providers', and IDUs in the long run can then access services from different institutions on their own.

DICs can offer more than just safer practices, such as 'space for counselling', 'consultation with physicians', 'hanging out place for drug users (due to recreational facilities that are made available like television or playing carrom)'. They offer 'directly observed therapy' (DOTs) for tuberculosis and 'room for informal and formal interaction between Safer Practices staff and injection drug users'. Thus, the location of DICs should be strategically selected so that a larger number of drug users may access these services. The 'opening hours' and the 'user-friendliness' of the DICs are two other closely linked issues that will determine the effectiveness of a DIC.

# 5. MONITORING AND QUALITY CONTROL

Both process indicators as well as outcome indicators are important in monitoring the services for Safer Practices as well as in assessing the quality of the intervention.

Monitoring and quality control should ensure not only an active contact of the IDUs with the services but also actual reduction of risks of IDUs to HIV and sexually transmitted infections (STIs). Three major areas that frequently escape the attention of the outreach coordinators in this regard are:

- adequacy of the number of syringes and needles provided to the IDUs
- sharing of injection paraphernalia such as water sachets used for cleaning injecting equipment following drug use by a group of drug users, and
- sexual risk reduction among IDUs and their sex partners

Objectively verifiable indicators (OVIs) specific to certain aspects of the services for Safer Practices serve best for monitoring when they are developed in consultation with the staff involved in the respective area. Sometimes, bringing staff together from different areas for developing OVIs proves beneficial as there are cross-cutting issues that involve several different aspects of these services.

Process indicators (such as involvement of IDUs in assessment, design of intervention, implementation and evaluation, persons met with for advocacy and development of advocacy strategies, IDUs reached in an area through Safer Practices, etc.) as well as outcome indicators (reduction in sharing of injection equipment, consultations sought for sickness episodes, etc.) are equally important to examine if the programme will realise its ultimate goal. A suggested checklist for monitoring day-to-day activities of Safer Practices is as follows:

1. Number of community sensitisation meetings held–topics discussed, achievements made, follow up action
2. Number of advocacy meetings held with the police–topics discussed, achievements made, follow up action
3. Number of sex partners of IDUs reached through Safer Practice services (by unit time, by gender)
4. Number of IDUs reached through Safer Practice activities (by unit time, by gender)
5. Frequency of contact per IDU in a month (by outreach worker)

6. Number of syringes provided per IDU in a month
7. Number of needles provided per IDU in a month
8. Number of IDUs contacted by each outreach worker during the reported month (new clients / fixed clients)
9. Number of clients accessing the DIC (by unit time, by gender)
10. Number of condoms received by IDUs in a month
11. Referral on request for detoxification in a month
12. Number of IDUs catered for sexually transmitted infection (STI) management in a month
13. Number of sex partners of IDUs catered for STI management in a month
14. Uptake of HIV-VCTC per month by IDUs
15. Uptake of HIV-VCTC per month by sex partners of IDUs
16. Number of referrals made for HIV treatment for IDUs in a month
17. Number of referrals made for HIV treatment for sex partners of IDUs in a month

# 6. CHECKLIST FOR MENTOR/S

While following a monitoring system (based on checklists) helps in improving the quality of work, a mentor/ consultant for the Safer Practices programme should, in addition, pay attention to the following issues:

- Is the staff recruited for Safer Practices programme getting enough opportunity to raise their concerns, ask questions and clarify doubts during training workshops? What was done apart from the initial training to improve the capacity of the project staff?
- What has been done to address the suggestions coming up from community, following sharing of the situation and response assessment findings?
- Has the sequence of having community sensitisation before launching Safer Practices been followed?
- What have been the processes of engaging different range of community stakeholders?
- Has the participation of drug users in every stage of assessment as well as subsequent intervention been ensured?
- Are the outreach coordinators maintaining their own logbook on field coordination without emphasising only on outreach workers for such a requirement?
- Problems should be raised in staff meetings (e.g., every Saturday) and solutions suggested?
- Has the safety of the outreach workers in the field been adequately ensured?[8]
- What is finally happening to the used and returned syringes and needles?
- Are the rules of 'not buying articles or accepting gifts from respondents' and 'not raising false hopes in the community' being followed?
- How effective has been the effort of reaching out to the sex partners of the IDUs and measures taken to improve upon this reach and quality of services in this regard?
- Have linkages been forged with health care outlets and addiction treatment centres where respondents can be referred in case necessity arise?
- Which of the referral linkages did not work out well, the reasons for their not working well and steps taken to rectify this?

[8] A mentor/consultant should check if used and returned syringes and needles are being collected by the outreach workers in a puncture proof container who should always carry it in the Outreach-Kit while going in the field for safer practice. Simple measures like this and vaccination of outreach workers against Hepatitis B go a long way in preventing accidental needle stick injury and infections resulting therefrom.

# 7. COSTING IN TERMS OF MANPOWER, MATERIALS AND TRAINING

The suggested monthly costing plan is based upon the assumption that one outreach worker is capable of reaching out to 20 to 30 IDUs a day and will meet them on alternate days and will have a fixed total clientele of 40 to 60 IDUs. Three male outreach workers will, therefore, be able to cover 120 to 180 IDUs. As about 60 per cent of the IDUs in South Asia are married, two female outreach workers will be required for reaching out to the 60 spouses of the 100 IDUs and will require less intense visits as a majority of them are not drug users.

**Suggested costing guidelines-** For a reach of 120 to 180 IDUs in a month and around 70 to 100 sex partners of those IDUs (the budget heads in 1st and 3rd column indicate monthly recurrent expenditures). Budgeting for any country specific programme should follow national norms.

| **Human resource (all full time except consultant)** | **Budget** | **Field work-** | **Budget** | **Training (one time expen-diture)** | **Budget** | **Sub total** | **5% contin-gency** | **Grand total** |
|---|---|---|---|---|---|---|---|---|
| One mentor / consultant<br>One team leader<br>One account cum administrative officer<br>One male outreach coordinator<br>Three male outreach workers<br>Two female outreach workers | | Movement for outreach<br>Costs related to behaviour change communication (events, leaflets, etc.)<br>Costs of materials for safer practices<br>Costs related to referral services | | 3 day training<br>Desktop PC with printer (one time expenditure) for report generation, communication and maintaining a computerised management information system<br>Exposure visits Within the region | | | | |
| | **Total budg-et for human resou-rce- A** | | **Total budget for field work-B** | | **Total budget for traini-ng- C** | **Sub total D = A+B+C** | **D* 0.05** | **E = D+D* 0.05** |

# 8. REFERENCES


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